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HOUSE BILL 2547 By
Eckles

SENATE BILL 2762
By Person

AN ACT to amend Tennessee Code Annotated, Title 56, relative to guaranteeing patient choice of mental health provider and freedom of access to care, thereby protecting consumer rights in their health care plans.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 56, is amended by adding Sections 2, 3, and 4, as new sections to be appropriately designated:

SECTON 2. Nothing in this act shall be construed as prohibiting an individual from purchasing any mental health services with the individual's own funds, whether or not the individual elects to use the benefits package of their choice or whether or not such services are covered within any benefits package otherwise available to the individual.

SECTION 3.

(1) "Health plan" means any hospital or health service policy or certificate, hospital or health service plan contract, or health maintenance organization, or managed care plan of any sort offered to individuals or groups in this state by an insurer or provider organized group, even if such insurers or provider groups do

not have their home office in this state. Such plans offer mental health services to individuals or groups as well as other types of basic health services.

(2) “Provider” means any qualified psychologist, psychiatrist, social worker, psychological examiner, professional counselor, marriage and family therapist and other qualified professionals licensed under Tennessee Code Annotated, Title 63, as well as licensed facilities, hospital or agencies that are qualified to engage in the assessment, prevention, diagnosis or treatment of mental health problems, including but not limited to the diagnosis and treatment of nervous and mental and substance abuse disorders.

(3) “Managed care plan” means a health service plan providing for the financing and delivery of health care services, including mental health and substance abuse services, to individuals or groups enrolled in such plans through (A) contractual arrangements with selected providers to provide mental health and substance abuse services, (B) organizational arrangements for ongoing quality assurance, utilization review programs, dispute resolution, and other self-regulatory procedures, (C) financial incentives for persons enrolled in the plan to use the participating providers and procedures provided for by the plan, (D) explicit guidelines for the selection of participating providers, and (E) are commonly offered to individuals or groups with discounted fees or capitated, risk-sharing arrangements of the sort commonly known as preferred provider plans, health maintenance organizations, or other similarly structured entities.

(4) “Mental health care” means any service related to the assessment, prevention, diagnosis or treatment of nervous and mental disorders, including substance abuse, as defined in the most recent editions of professionally recognized texts for the diagnosis of nervous and mental disorders and substance abuse disorders.

(5) “Provider network” refers to any health plan that restricts access, referrals or choice of mental health care providers, who have entered into a contractual agreement

with the plan under which such providers are obligated to provide supplies, treatment, and services under the said plan to eligible individuals or groups enrolled in these plans.

(6) In-network providers, facilities or services refer to those providers, facilities, or services provided to individuals or groups in health plans enrolled under such health plans.

(7) Out-of-network providers, facilities or services refer to providers, facilities, or services provided to an individual or groups who are not members of the provider network of such a health plan.

(8) “Utilization review” program means a system of reviewing clinical necessity, medical necessity, appropriateness or quality of health plan services or supplies by providers or facilities provided under a health plan or managed care plan using specified guidelines. Such a system may include preadmission certification, the application of practice guidelines, continued stay criteria, concurrent review, discharge planning, preauthorization or gatekeeping procedures for initiating services, outcomes requirements or measures, retrospective review, and other similar review mechanisms; and

(9) “Clinical necessity or medical necessity” shall mean services or supplies provided by a facility or mental health provider that are required to identify or treat individuals or groups of patients and are (A) consistent with the symptoms or diagnosis and treatment of the patient’s condition, disease, ailment or injury, and (B) appropriate with regard to standards of good professional practice, and (C) not solely for the convenience of a patient, provider, or facility; and (D) the most appropriate supply or level of service which can safely be provided to the patient. When applied to the care of an inpatient, it further means that services for the patient’s clinical or medical symptoms or condition require that the services cannot be safely provided to the patient as an outpatient.

SECTION 4

(a) Each health plan including those self-insured sponsors which utilizes a network of providers, supplies, or facilities of the sort commonly offered to individuals or groups in managed care plans shall offer to enrollees a point of service option, permitting such enrollees to receive all covered items and services for mental health and substance abuse care from providers or facilities that are not members of the plan' network, subject to those conditions described in subsection (b) through (g):

(b) A point-of-service plan may require deductibles and coinsurance from enrollees who elect to utilize the point-of-service option provided (1) the deductible does not exceed by two hundred fifty dollars ($250.00) annually the deductible amounts offered by any of the managed care plans offered to enrollees, (2) the coinsurance percentage of payment at usual and customary rates does not exceed an amount of twenty percent (20%) greater than the coinsurance requirements for any of the managed care plans offered to enrollees, and (3) the applicable coinsurance percentage may be applied differentially with respect to in and out of network providers or facilities as described in subsection (b).

(c) For any point-of-service option chosen, the enrollee shall retain the right for self-referral and shall not be required to possess a referral from another provider, primary care provider, employee assistance program, or other similar gatekeeper or preauthorization person(s) or facilities in order to access their point-of-service plan.

(d) For any point-of-service option chosen, the enrollee shall not have to undergo either precertification or utilization review programs in order to begin or continue care within the provisions of the point-of-service plan, provided such services have been deemed to be clinically or medically necessary.

(e) A premium difference reflecting the true differences in costs between the point-of-service option and any of the managed care plans offered to enrollees may be

assessed provided that the insurer does not profit any more from the point-of-service plan than the insurer does from any of the managed care plans offered to enrollees and provided over eighty-five percent (85%) of the premium difference costs are spent on direct patient care, not administrative costs.

(f) Except for annual premiums, deductibles and copayments, the mental health benefit package offered the enrollee shall be the same between the point-of-service option and any of the managed care plans offered the enrollees; and

(g) A health plan may deny payment to providers or facilities for services or supplies not deemed to be clinically or medically necessary.

SECTION 5. This act shall take effect July 1, 1998, the public welfare requiring it.